DIVISION OF WORKERS COMPENSATION

KS DEPT OF LABOR 800 SW JACKSON ST STE 600 TOPEKA KS 66612-1227

Phone (785) 296-3441 Fax. (785) 291-3430

E-mailwww.dol.ks.gov

Employee's Name:			
			APPLICATION FOR HEARING
First	Middle	Last	
Date of Birth:	() Male	() Female	- I
Social Security Number:			Employer:
Social Security Number			Street:
Street:			_
			City: State: Zip:
City:	State:	Zip:	Insurance Carrier:
			moditation dutitor.

,	Insurance Carrier:			
Phone Number:	(Required)			
ACCIDENTAL INJURY O	R OCCUPATIONAL DISEASE			
Date of accident/disease (give beginning and ending dates if a seri	es):			
State specifically the exact cause and source of accident/disease	o:			
Briefly state extent of injuries or disease claimed:				
In what county did the accident or disease occur? At or near which city?				
If accident/disease did not happen within Kansas, in which Kansas c	ounty could hearing be most conveniently held?			
Mediation Requested? YES NO (circle one)				
Applicant's Signature:	Date Signed:			
A	ttorney's Signature:ttorney's Printed Name:ddress:			
E	elephone Number: ()			

Federal Privacy Act Disclosure Section 7(a)(2)(B)

The mandatory requirement that social security numbers be included on forms filed with the Division of Workers Compensation is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, since our regulations which require its disclosure were in existence before January 1, 1975. The number is used as a means of identifying all the various records in the Division of Workers Compensation pertaining to an individual.

The use of social security numbers is made necessary because of the large number of applicants who have similar names and birth dates, and whose identities can only be distinguished by the social security number.